PRIOR AUTHORIZATION REQUEST FORM

Please complete all sections. Incomplete forms will be returned.

1. PATIENT INFORMATION

Full Name: John Michael Doe DOB: 01/15/1980 Sex: M F
Member ID: BCBS123456789 Insurance: Blue Cross Blue Shield
Address: 123 Main Street, Anytown, ST 12345
Phone: (555) 123-4567 Email: john.doe@email.com

2. INSURANCE / PLAN INFORMATION

Insurance Company: Blue Cross Blue Shield Plan Type: PPO HMO Medicare
Policy Number: POL987654321 Group Number: GRP001
Effective Date: 01/01/2024 Termination Date: 12/31/2024

3. PROVIDER INFORMATION

Requesting Provider: Dr. Sarah Smith, MD NPI: 1234567890
Specialty: Neurology Cardiology Orthopedics Other: _____
Phone: (555) 987-6543 Fax: (555) 987-6544
Address: 456 Medical Center Dr, Anytown, ST 12345
Facility: Anytown Medical Center Tax ID: 12-3456789

4. SERVICE / PROCEDURE REQUESTED

Service Type: MRI Brain with Contrast
CPT Code: 70553 ICD-10 Code: R51 - Headache
Number of Treatments: 1 Requested Date: 12/20/2024
Place of Service: Outpatient Inpatient Emergency Other: _____

5. CLINICAL JUSTIFICATION

Medical Necessity:

Patient presents with persistent headaches and dizziness for 3 weeks. Physical examination reveals no focal neurological deficits. Patient has history of hypertension, well controlled. MRI brain with contrast is medically necessary to rule out intracranial pathology including mass lesions, vascular abnormalities, or acute stroke. Clinical guidelines support MRI imaging for persistent headaches with associated symptoms.

Clinical Findings:

Headaches (duration: 3 weeks) Dizziness Nausea
Photophobia No focal deficits Normal vitals

Prior Treatments:

OTC medications (no relief) Rest Other: _____

6. SUPPORTING DOCUMENTATION

Attached Documents (check all that apply):

Physician Notes (12/15/2024) Laboratory Results (CBC, CMP)
Previous Imaging (CT Head) Patient Medical History
Insurance Card Copy Discharge Summary
Consultation Reports Other: _____